STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012309	A. BUILDING: _____ B. WING _____	C 08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint # IN00133747. Complaint # IN00133747- Substantiated. No deficiencies related to the allegations are cited. Survey date: August 26, 2013 Facility number: 012309 Provider number: N/A AIM number: N/A Survey team: Michelle Carter, RN - TC Census bed type: Residential- 33 Total- 33 Census Payor type: Medicaid - 23 Other- 10 Total- 33 Sample: 7 Crownpointe of Carmel was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint # IN00133747. Quality Review 08/27/13 by Lisa McColly	R 000		